SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

Date: _____

Provider or Department Name: _____ Provider or NPI: _____

Contact Person: _____ Phone Number: _____

I. ADD INSURANCE FOR A MEDICAID BENEFICIARY WITH NO INSURANCE IN THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – ALLOW 25 DAYS

Beneficiary Name: _____ Date Referral Completed: _____

Medicaid ID #: _____ Policy Number: _____

Insurance Company Name: _____ Group Number: _____

Insured's Name: _____ Insured SSN: _____

Employers' Name/Address: _____

II. CHANGES TO AN INSURANCE RECORD THAT IS IN MMIS – MIVS WILL MAKE NECESSARY CHANGES TO THE RECORD WITHIN 5 DAYS

☐ A. Beneficiary has never been covered by the policy – Close Insurance

☐ B. Beneficiary coverage ended – terminate coverage (date): _____

☐ C. Subscriber coverage lapsed – terminate coverage (date): _____

☐ D. Subscriber changed plans under employer – New Carrier is: _____

New Policy Number is: _____

☐ E. Beneficiary to add to insurance already in MMIS for subscriber or other family member.

Name: _____

ATTACH A COPY OF THE APPROPRIATE DOCUMENTATION TO THIS FORM

Submit this information to Medicaid Insurance Verification Services (MIVS)

Fax	**or**	**Mail**
803-252-0870		Post Office Box 101110 Columbia, SC 29211-9804